1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6425

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 FilmC217 6-28-57 et

06406

Reg. Dist. No. 201

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETTERTON
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Betterton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOSEPH — Middle: LEWIS — Last: BENNETT
4. DATE OF DEATH: Month: June — Day: 13 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 9, 1888
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Electric Co.
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Taylor Bennett
14. MOTHER'S MAIDEN NAME: Annie E. Rambo (wife) Betterton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 161-03-5147
17. INFORMANT: Mary Bennett (wife) Address: Betterton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Probable congestive heart failure	1 month
DUE TO (b)	Pulmonary emphysema	Several years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 527.1 510.0 DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Peptic ulcer - Probable coronary artery disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐. 11:30 AM

ACTUAL SIGNATURE: Robert W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): ROBERT W. FARR
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/13/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6-17-57
22c. NAME OF CEMETERY OR CREMATORY: GRACELAWN MEM. PARK
22d. LOCATION (City, town, or county) (State): WILMINGTON DEL.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy
ADDRESS: STILL POND, MD.
24a. RECD BY REGISTRAR DATE: 6/17/57
24b. REGISTRAR'S SIGNATURE: E Kennard Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06407

6426

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 41 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2. Chestertown
d. STREET ADDRESS: / Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Ada — Middle: Elizabeth — Last: Grussing

4. DATE OF DEATH: Month: June — Day: 27, — Year: 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July I9, I882

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Howard Co. Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Davis

14. MOTHER'S MAIDEN NAME: Mary Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: no

17. INFORMANT: George Grussing — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Circulatory collapse — INTERVAL BETWEEN ONSET AND DEATH: 2 days

4427

DUE TO (b): Cardiovascular renal disease — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 450.9

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19___, to June 27, 19 57, that I last saw the deceased alive on June 24, 19 57, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Dick — M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 6-29-57

PHYSICIAN'S NAME (Type): A. C. Dick - Chestertown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: June 30, I957 — 22c. NAME OF CEMETERY OR CREMATORY: Chester Cem. — 22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 2 1957 — 24b. REGISTRAR'S SIGNATURE: Chas. L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 [redacted] be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06408

6427

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown (Rural)
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First George — Middle V. — Last Hatcherson

4. DATE OF DEATH: Month June — Day I3, — Year 19I957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 7, I878

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert R. Hatcherson

14. MOTHER'S MAIDEN NAME: Catherine Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 2I5-36-I695

17. INFORMANT: A - Robert R. Hatcherson — Address: Chestertown Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Hypertensive Cardio Vascular.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hemiplegia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1957, to June 13, 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C. Nitsch M.D. — ADDRESS (Street, city or town, state): Rock Hall, Md. — DATE SIGNED: June I3, I957

PHYSICIAN'S NAME (Type): Norbert C. Nitsch - Rock Hall, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: June I6, I957 — 22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cem. — 22d. LOCATION (City, town, or county) (State): nr. Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: JUN 17 1957 — 24b. REGISTRAR'S SIGNATURE: Chas. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6428

CERTIFICATE OF DEATH

06409

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
c. LENGTH OF STAY IN 1b: life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Worton
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

3. NAME OF DECEASED (Type or print): First Gertrude Middle Carter Last Jones

4. DATE OF DEATH: Month June Day 16 Year 1957

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 1 1890

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): storekeeping

10b. KIND OF BUSINESS OR INDUSTRY: general

11. BIRTHPLACE (State or foreign country): Worton Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm. David Carter

14. MOTHER'S MAIDEN NAME: Mary Eliz. Rasin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 220-32-9717

17. INFORMANT: Mrs. John M. Clayton Address: Worton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

DUE TO

442 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): hypertensive renal disease — 5 years

DUE TO

(c): hypertension — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic cardiac decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1954, to June, 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 7A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Florence Deringer Joyce M.D.

ADDRESS (Street, city or town, state): Worton Md

DATE SIGNED: 6/16/57

PHYSICIAN'S NAME (Type): Florence Deringer Joyce — Worton Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 18/57

22c. NAME OF CEMETERY OR CREMATORY: Still Pond Cemetery

22d. LOCATION (City, town, or county) (State): Still Pond Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams

ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: June 18-57

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6429

CERTIFICATE OF DEATH

06410

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Chestertown
d. STREET ADDRESS: / R ural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Philip — Middle: L. — Last: Leager

4. DATE OF DEATH: Month: June — Day: 28, — Year: I957 — 19

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April IO, I909

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alonza Leager

14. MOTHER'S MAIDEN NAME: Sidney Trimble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: YES.

17. INFORMANT: Mrs. Philip Leager — Address: Chestertown, Md. Rural

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/27, 1957, to 6/28, 19 57, that I last saw the deceased alive on 6/28, 19 57, and that death occurred at 8:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert Farr M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 6-29-57

PHYSICIAN'S NAME (Type): Robert W. Farr — Chestertown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 30, I957
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JUL 2 1957
24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6418

06411

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert St.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: Calvert St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Willie Wm. Middle Lively (or) Last Lindsey
4. DATE OF DEATH: Month June Day 18 Year I957 19

5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. I902
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Ice Plant
11. BIRTHPLACE (State or foreign country): Kent Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi Lively
14. MOTHER'S MAIDEN NAME: Louise Lindsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 2I6-I6-7I0I
17. INFORMANT: Viola Foreman — Address: 436 Moorehouse Drive Wilmington - Dela.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Natural Causes - unknown — INTERVAL BETWEEN ONSET AND DEATH: less than 2 days

DUE TO (b): No history of physical ailment obtainable. Deceased had been working XXXXXXX every day and had been observed to have been drinking heavily the day before. He was found dead on the stairway of his home the morning of June 18, 1957. There was no sign of injury.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL CONDITION GIVEN IN PART I (a) — AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour ___ a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: Robert W Farr M.D.
EXAMINER'S NAME (Type): Robert W. Farr Chestertown Maryland
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: June 20 I957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 22, I957
22c. NAME OF CEMETERY OR CREMATORY: Pomona Cem. near
22d. LOCATION (City, town, or county) (State): Chestertown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JUN 21 1957
24b. REGISTRAR'S SIGNATURE

THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6419 06412

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 1 Wk.
d. NAME OF HOSP.TAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kentucky — b. COUNTY: Harlan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: L. — Last: Livingston

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1957

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 19 1884

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mining

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm. Livingston

14. MOTHER'S MAIDEN NAME: Cora LLoyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 400-09-4230

17. INFORMANT: Address: Mrs. Ann Livingston Cumberland Kentucky

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO (b): Arteriosclerotic heart disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchiectasis, Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1957, to June 10, 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 2:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D. — ADDRESS (Street, city or town, state): Rock Hall, Md — DATE SIGNED: 6/10/57

PHYSICIAN'S NAME (Type): Willard Smith — Rock Hall, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/13/57

22c. NAME OF CEMETERY OR CREMATORY: Cumberland

22d. LOCATION (City, town, or county) (State): Cumberland Kentucky

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md

24a. REC'D BY REGISTRAR: June 12-1957

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

Marvin V. Williams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6430 Items [illegible]

CERTIFICATE OF DEATH

06413

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennedyville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennedyville
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: Tharon — Last: Manley

4. DATE OF DEATH: Month: June — Day: 1 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 27, 1907

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Manley

14. MOTHER'S MAIDEN NAME: Eva C. Eubank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mary Manley — Address: Kennedyville Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompersation — INTERVAL BETWEEN ONSET AND DEATH: 1 day

HIGX

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Old rheumatic heart disease — Many years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-21, 19 56, to 11-27, 19 56, that I last saw the deceased alive on 11-27, 19 56, and that death occurred at 12:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick — M.D.

ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JUNE 4

22c. NAME OF CEMETERY OR CREMATORY: DOUBLE CREEK

22d. LOCATION (City, town, or county) (State): McGINNESS CORNER MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane — ADDRESS: Church Hill

24a. RECEIVED BY REGISTRAR DATE: JUN 6 1957

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Patient has been a recent inmate of the Vans Hospital at Perry Point, Md. and was home on leave when he became ill and shortly died. Diagnosis based on data obtained when patient was last seen.

VS A15 (4) 15M 9/55

1

Items 18, 20 Film 217 7-5-57 amg

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6431

06414

Reg. Dist. No. 01

M

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERVILLE
c. LENGTH OF STAY IN 1b: 18 Mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERVILLE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ELIZABETH — Middle DISHINGTON — Last REID

4. DATE OF DEATH: Month JUNE — Day 21 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: APRIL 18, 1896

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (State or foreign country): SCOTLAND

12. CITIZEN OF WHAT COUNTRY? GREAT BRITIN

I

13. FATHER'S NAME: THOMAS DISHINGTON

14. MOTHER'S MAIDEN NAME: JANE COCHBURN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. BETTY CALLOWAY — Address: MILLINGTON MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degeneration of the heart muscle — INTERVAL BETWEEN ONSET AND DEATH: 8 weeks.
DUE TO
(b): Cerebral hemorrhage — One week.
DUE TO
(c): Fracture of the hip bone — 5 weeks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral arteriosclerosis — Decubitus —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Patient slipped while walking in her room.

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: 5/18/ 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 18, 1957, to June 21, 1957, that I last saw the deceased alive on June 20, 1957, and that death occurred at 7.55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Geza Koralewski M.D.
ADDRESS (Street, city or town, state): MILLINGTON
DATE SIGNED: 6.21.57.

PHYSICIAN'S NAME (Type): GEZA KORALEWSKI — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/24/57
22c. NAME OF CEMETERY OR CREMATORY: CHESTERFIELD CEMETERY
22d. LOCATION (City, town, or county) (State): CENTREVILLE MD

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar F. Soan — ADDRESS: CHURCH HILL, MD.

24a. REC'D BY REGISTRAR DATE: JUN 25 1957
24b. REGISTRAR'S SIGNATURE: E. Howard Price

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6432

CERTIFICATE OF DEATH

06415

Reg. Dist. No. 203

1. PLACE OF DEATH
a. COUNTY: KENT
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b: LIFE TIME
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: --

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle L Last SAPPINGTON
4. DATE OF DEATH: Month JUNE Day 22 Year 1957
5. SEX: FEMALE
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 16, 1869 (1869/1871)
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: BENJAMIN F. SAPPINGTON
14. MOTHER'S MAIDEN NAME: FANNIE WICKES.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FRANKLIN Address: WOOD. ROCK HALL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
4 d - 1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Arteria Sclerosis, Cardio Vascular — Unknown
DUE TO (c): Senility
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 21, 1957, to June 22, 1957, that I last saw the deceased alive on June 22, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Norbert C Nitsch M.D. ADDRESS (Street, city or town, state): Rock Hall DATE SIGNED: June 24/57
PHYSICIAN'S NAME (Type): NORBERT C NITSCH ROCK HALL MD

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: JUNE 25.
22c. NAME OF CEMETERY OR CREMATORY: WESLEY CHAPEL
22d. LOCATION (City, town, or county): ROCK HALL (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lamotte ADDRESS: Church Hill
24a. REC'D BY REGISTRAR DATE: JUN 26 1957
24b. REGISTRAR'S SIGNATURE: J. Elwood Burgess
Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 [redacted] be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06416

6420 **CERTIFICATE OF DEATH** Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent and Queen Anne's Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: Mill Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah — Middle Rebecca — Last Shinn

4. DATE OF DEATH: Month June — Day 25, — Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 16, 1878

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chestertown, Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Victor Hendrickson

14. MOTHER'S MAIDEN NAME: Sally Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-34-3647

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Cardio-vascular-renal disease — 7 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1950, to June 25, 1957, that I last saw the deceased alive on June 25, 1957, and that death occurred at 10 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D.

ADDRESS (Street, city or town, state): Chestertown, Md.

DATE SIGNED: 6-25-57

PHYSICIAN'S NAME (Type): A.C. Dick.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 28, 1957

22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

22d. LOCATION (City, town, or county) (State): Chestertown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells

ADDRESS: Chestertown, Md.

24a REC'D BY REGISTRAR: JUN 28 1957

24b. REGISTRAR'S SIGNATURE: Clara Hanson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06417

6421

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: KENT. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 2 HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT & QUEEN ANNE'S HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PATRICIA Middle E. Last SMITHSON

4. DATE OF DEATH: Month JUN Day 14 Year 1957

5. SEX: F
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APR 28, 1943
9. AGE (In years last birthday): 14 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: CHARLES D. SMITHSON
14. MOTHER'S MAIDEN NAME: ETHEL RODNEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Address: HOSP. CHART.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS, generalized
DUE TO
(b): Carcinoma of Ovary
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APR 1, 19 57 to JUN 14, 19 57 that I last saw the deceased alive on JUN 14, 19 57, and that death occurred at 1:02 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. T. [illegible] M.D.
ADDRESS (Street, city or town, state): CHESTERTOWN Md.
DATE SIGNED: 6-14-57

PHYSICIAN'S NAME (Type): A. T. KEEFE JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 6/17/57
22c. NAME OF CEMETERY OR CREMATORY: Stephens
22d. LOCATION (City, town, or county) (State): Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane
ADDRESS: Church Hill
24a. REC'D BY REGISTRAR DATE: JUN 19 1957
24b. REGISTRAR'S SIGNATURE: Clara Bracey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6433

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06418 03

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: KENT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL (Rural)
c. LENGTH OF STAY IN 1b: Life -
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FANNIE Middle MARLIN Last VANSANT

4. DATE OF DEATH: Month June Day 15 Year 1957

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 22, 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Glenn
14. MOTHER'S MAIDEN NAME: Tory — — —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Chas S. Vansant, Rock Hall, Md Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probable coronary thrombosis c ventricular arrest — sudden
DUE TO (b): arterial hypertension — several years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1+4+X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert Farr M.D.
EXAMINER'S NAME (Type): ROBERT W. FARR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/15/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/18/57
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel
22d. LOCATION (City, town, or county) (State): Rock Hall Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Sampson ADDRESS: Church Hill Md.
24a. REC'D BY REGISTRAR DATE: JUN 19 1957
24b. REGISTRAR'S SIGNATURE: J. E. Burgess

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(5)
SM 9/55

1

M

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6422

CERTIFICATE OF DEATH

06419

Reg. Dist. No. 702

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: 20 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes Hospital

d. STREET ADDRESS: 118 Front Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Vinyard

4. DATE OF DEATH: Month: June — Day: 21 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: May 6, 1907

9. AGE (In years last birthday): 50 yrs

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat cutter

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herman W. Vinyard

14. MOTHER'S MAIDEN NAME: Elizabeth Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis

4-25-41

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/18/57, 19____, to 6/21, 1957, that I last saw the deceased alive on 6/21, 1957, and that death occurred at 11:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. C. Dick M.D.

ADDRESS (Street, city or town, state): Chestertown, Md.

DATE SIGNED: 6/21/57

PHYSICIAN'S NAME (Type): A. C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-26-57

22c. NAME OF CEMETERY OR CREMATORY: Barratt's Chapel

22d. LOCATION (City, town, or county) (State): Frederica, Del.

23. FUNERAL DIRECTOR'S SIGNATURE: William Berry Jr. — ADDRESS: Milford, Del.

24a. REC'D BY REGISTRAR DATE: JUN 28 195

24b. REGISTRAR'S SIGNATURE: Clara Lassey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6423 06420

CERTIFICATE OF DEATH

Reg. Dist. No. 7-4

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hospital

d STREET ADDRESS: 603 High St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry Middle Frank Last Willis

4. DATE OF DEATH: Month June Day 13 Year 19 I957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 2I, I894

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: Tenant

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Willis

14. MOTHER'S MAIDEN NAME: Willie Legg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT: Hospital Records Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Rupture of abdominal aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b): Hypertensive cardio-Vascular disease — years

DUE TO (c):

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

1X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19.53, to June 13, 19.57, that I last saw the deceased alive on June 13 1957, and that death occurred at 6:I P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D.

ADDRESS (Street, city or town, state): Rock Hall, Md.

DATE SIGNED: 6/I4/57

PHYSICIAN'S NAME (Type): Willard F. Smith

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June I5, I957

22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

22d LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E Willis Wells ADDRESS: Chestertown, Md.

24a. RECEIVED BY REGISTRAR DATE: JUN 17 57

24b. REGISTRAR'S SIGNATURE: Vera A Brassy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6424

CERTIFICATE OF DEATH

06421

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT & QUEEN ANNE'S HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 CHESTERTOWN
d. STREET ADDRESS: 411 CALVERT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BETTY — Middle JEAN — Last WILMER

4. DATE OF DEATH: Month JUN — Day 13 — Year 1957

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV 8, 1941

9. AGE (In years last birthday): 15 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: STUDENT

11. BIRTHPLACE (State or foreign country): CHESTERTOWN, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES WILMER

14. MOTHER'S MAIDEN NAME: ANNA JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NO

17. INFORMANT — Address: HOSPITAL CHART.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): FRACTURED LIVER Auto accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

825X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTOMOBILE ACCIDENT.

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: JUN 11 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ROAD

20f. (City or town) (County) (State): QUEENANNE MD.

21. I certify that I attended the deceased from JUN 11, 1957, to JUN 13, 1957, that I last saw the deceased alive on JUN 17, 1957, and that death occurred at 9:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): CHESTERTOWN Md. — DATE SIGNED: 6-18-57

PHYSICIAN'S NAME (Type): A. T. KEEFE, JR. M.D. — W. Harry Fridinger Asst. Med Exam. for 2 A Co. Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 17, 1957

22c. NAME OF CEMETERY OR CREMATORY: Still Pond Col. Cem.

22d. LOCATION (City, town, or county) (State): Still Pond Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JUN 18 1957

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6434

CERTIFICATE OF DEATH

06422

Reg. Dist. No. 203

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b: 30 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: CHRISTIAN Last: WITT

4. DATE OF DEATH: Month: JUNE Day: 18 Year: 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 25, 1885

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOAT CAPTAIN

10b. KIND OF BUSINESS OR INDUSTRY: WATERMAN

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIE F. WITT

14. MOTHER'S MAIDEN NAME: AMELIA WITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 220-32-8725

17. INFORMANT: Address: MRS. EOLIN D. WITT, ROCK HALL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertension - Cerebrovascular
DUE TO (b): Arteriosclerosis
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4437

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1 1956 to June 18 1957 that I last saw the deceased alive on June 18 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C Nitsch M.D.
ADDRESS (Street, city or town, state): Rock Hall
DATE SIGNED: June 20/57
PHYSICIAN'S NAME (Type): NORBERT C NITSCH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JUNE 21, '57
22c. NAME OF CEMETERY OR CREMATORY: WESLEY CHAPEL
22d. LOCATION (City, town, or county) (State): ROCK HALL MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lowe, Sr.
ADDRESS: CHURCH HILL MD.

24a. REC'D BY REGISTRAR DATE: JUN 21 1957
24b. REGISTRAR'S SIGNATURE: Elwood Burgess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS